

ASSESSMENT INFORMATION

DATE _____ AGE _____

NAME _____

CURRENTLY INCARCERATED ____ NO ____ YES, SINCE _____

ANTICIPATED RELEASE DATE _____

BOND SET / POSTED _____ BAC

***PRESENTING PROBLEM**

(date of arrest, charge, date of sentencing, *client version of events)

***PRIOR AND PENDING ARRESTS, CONVICTIONS, DEFERRED PROSECUTIONS** (juvenile/adult charges, original charge if plea, BAC, *current legal status)

***FAMILY HISTORY & ENVIRONMENTAL SETTING**

CURRENTLY MARRIED _____ DIVORCED _____

NEVER MARRIED _____ WIDOWED _____

CURRENT RELATIONSHIP: NAME _____

LENGTH / TYPE OF RELATIONSHIP _____

CHILDREN WITH THIS PERSON (names, ages, who they live with)

PRIOR MARRIAGES / SIGNIFICANT OTHER RELATIONSHIPS:
(name, duration, any children—ages)

PARENTS ARE: MARRIED _____ DIVORCED _____

SEPARATED _____ NEVER MARRIED _____

CLIENT ADOPTED _____

SOCIO-ECONOMIC STATUS GROWING UP _____

FATHER—LIVING YES _____ NO _____

DATE AND CAUSE OF DEATH:

RELATIONSHIP WITH FATHER—PAST/PRESENT:

STAFF COMMENTS

* Denotes area required in governing rules.

MOTHER—LIVING YES____ NO____
DATE AND CAUSE OF DEATH:

RELATIONSHIP WITH MOTHER—PAST/PRESENT:

NAME OF BROTHERS/SISTERS, AGES, RELATIONSHIP WITH
SIBLINGS:

***EDUCATION**

LAST GRADE ATTENDED _____ GRADES _____

NAME OF LAST SCHOOL _____

PROBLEMS IN SCHOOL (expulsions, suspensions, withdrawal)

COLLEGE / TRADE SCHOOL: YES____ NO____

DEGREE: _____

SCHOOL NAME: _____

***MILITARY SERVICE**

BRANCH _____ YEARS _____

DISCHARGE TYPE / RANK: _____

HIGHEST RANK: _____

DISCIPLINARY ACTIONS:

***EMPLOYMENT**

WHERE _____

LENGTH OF TIME _____ HOURS/SHIFT _____

JOB _____

*HOURLY PAY OR SALARY _____

SUPPLEMENTAL INCOME (Child Support / Social Security Disability / Veterans
Benefits)

STAFF COMMENTS

* Denotes area required in governing rules.

***SOCIAL AND PEER GROUP:**
(type and amt of friends, hobbies)

STAFF COMMENTS

***HISTORY OF MEDICAL PROBLEMS:**

***HISTORY OF MENTAL HEALTH PROBLEMS:**

*CURRENT/RECENT THOUGHTS OF SUICIDE/HOMICIDE _____

PLAN? _____ YES _____ NO (if yes, what is the plan?)

CLIENT VICTIMIZATION: PHYSICAL _____ SEXUAL _____

VERBAL / EMOTIONAL _____

INFORMATION REGARDING ABUSE:

***HISTORY OF SUBSTANCE ABUSE:**

*SUBSTANCE(S) OF
PREFERENCE _____

*HISTORY OF SUBSTANCE ABUSE INTERVENTION (Education,
Outpatient, Detox, IOP, Residential, Halfway House):
(date, where, type of intervention, reason for intervention)

***HISTORY OF SUBSTANCE ABUSE/ADDICTION IN FAMILY AND
ATTITUDE TOWARD SUCH USE:** (relationship to client and substance used)

***PHYSICAL SYMPTOMS (Adverse Reactions)**

SUBSTANCE(S)

HANGOVERS_____

PASSOUTS_____

BLACKOUTS_____

TOLERANCE_____

LOSS OF CONTROL_____

RELIEF USE_____

OVERDOSE_____

ADVERSE DRUG REACTION_____

WITHDRAWAL SYMPTOMS (SPECIFY)_____

WHO HAS EXPRESSED CONCERN ABOUT *YOUR* USE:

CLIENT IDENTIFIED SYMPTOMS OF CONCERN:

ADDITIONAL SERVICES INDICATED: (Please circle all that apply)

Workforce Development AFDC Medicaid/Medicare

Food Stamps Medical/Clinic Housing

Other_____

STAFF COMMENTS

Professional Staff Member

Date

* Denotes area required in governing rules.